

AIG Life Insurance Company*

Wilmington, Delaware

A member company of American International Group, Inc.

Return Claim To: AIG Claims Department , P.O. Box 43119, Las Vegas, NV 89116-1119

*This company does not solicit business in New York.

HOW TO SUBMIT YOUR CLAIM - PLEASE PRINT

STEP 1. Complete Part A. Date and sign for all claims.

STEP 2. Complete Part B. The authorization to pay benefits to the physician is to be signed if you wish payment to be made directly to the health care provider.

STEP 3. Sign and date the Authorization for Release of Information.

STEP 4. Have your attending physician complete Part C.

STEP 5. When you and your attending physician have completed the form, mail it along with the signed Authorization for Release of Information and all related medical bills to the address listed above for review and processing.

PART A TO BE COMPLETED BY INSURED

Please Note: Failure to complete this form IN FULL may delay payment of your claim.

Complete For All Claims

- 1. Insured's Name _____
- 2. Date of Birth _____
- 3. Social Security Number _____
- 4. Policy Number(s) _____
- 5. Home Address _____
- 6. Home Phone _____
- 7. Office Phone _____

Complete For Dependent Claims Only

- 8. Dependent's Name _____
- 9. Dependent's Date of Birth _____
- 10. Relationship: Spouse Son Daughter Other _____ Residence _____
- 11. Full time student Yes No If "Yes", and 18 years or older provide name and address of school: _____

Complete For All Claims

- 13. Describe condition: _____
- 14. Was condition caused by claimant's employment? Yes No If "Yes" has or will a claim be filed with the Workers' Compensation carrier? Yes No Result? Accepted Denied Pending Name of Workers' Compensation carrier _____
- 15. Date symptoms first noticed _____
- 16. Date first consulted physician _____
- 17. Name(s) and address(es) of physician(s) consulted for this condition or any similar or related condition: _____

18. Did the injury or illness require hospital confinement? Yes No If "Yes" provide the name of the hospital and dates confined: _____

19. Is the person for whom this claim is made covered under any other group health or service plan, or federal medicare program? Yes No

20. If "Yes" is other coverage: Employer Plan Union Plan Private Plan Student Plan Other: _____

A. Insured Member's Name _____ B. Policy/Member No. _____

C. Member's Soc. Sec. No. _____ D. Effective Date _____

E. Name, address, and phone number of insurance company or organization providing benefits or service: _____

Complete For Accident Claims Only

21. Date of accident _____ 22. Was claimant at work when accident happened? Yes No

23. Where did accident happen? _____

24. How did accident happen? _____

Date and Sign for ALL Claims

25. I/We certify that the above information is true and correct. (If claim is for spouse, spouse must also sign.) A photographic copy of this certification shall be considered as effective and valid as the original. I have read the Fraud Statement included with this form.

Date

Signature of Spouse

Signature of Insured

PART B TO BE COMPLETED BY PATIENT/OR INSURED

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: (OPTIONAL)

I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

Date Signature - Insured Person

PART C TO BE COMPLETED BY ATTENDING PHYSICIAN

- Patient's Name _____ Date of Birth: _____
If patient is a minor, Insured's name: _____ Policy No.: _____
- Diagnosis and concurrent conditions: (If diagnosis code other than ICD* used, give name)

- Pregnancy? Yes No If "Yes", what is the expected date of delivery? _____
- Is condition due to injury or sickness arising out of patient's employment? Yes No
- Report of Services (or attach itemized bill*) (If previous form submitted to this carrier, you need show only dates and services since last report.)

DATE OF SERVICES	PLACE OF SERVICES	DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED	CODE IF USED RVS** OR CPT***	CHARGES
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
†0-Doctor's Office	IH-Inpatient Hospital	NH-Nursing Home	TOTAL CHARGES ▶ \$	_____
H-Patient's Home	OH-Outpatient Hospital	OL-Other Locations	AMOUNT PAID ▶ \$	_____
*ICD - International Classification of Diseases			BALANCE DUE ▶ \$	_____
**RVS - Relative Value Studies				
***CPT - Current Procedural Terminology (Current edition)				

- Date symptoms first appeared or accident happened _____
- Date patient first consulted you for this condition _____
- Has the patient ever had the same or similar condition? Yes No If "Yes" when and describe _____
- Is the patient still under your care for this condition? Yes No (If "No" give date your services terminated.) _____
- Was laboratory work performed outside your office? Yes No If "Yes" name of facility _____
- Name of referring physician _____
- Was the patient hospital confined? Yes No If "Yes", From _____ Thru _____
Name and address of hospital _____
- Is the person for whom this claim is made covered under any other Health/Service plan? Yes No If "Yes" Name _____
Medicare? Yes No (Medicare No. _____) Med-Cal? Yes No (Med-Cal No. _____)
Other Government/Welfare/Aid program? Yes No If "Yes" Name _____

SIGNATURE (Attending Physician) DATE PHONE NUMBER

PHYSICIAN'S NAME (Please Print) TAX ID NUMBER PATIENT'S ACCOUNT NUMBER

STREET ADDRESS CITY STATE ZIP CODE

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Claimant's Name	Date of Birth	Social Security Number
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I hereby authorize all of the people and organizations listed below to give AIG Life Insurance Company and the American General Life Companies LLC, (an affiliated service company), (collectively the "Companies"), and their authorized representatives, including agents and insurance support organizations, (collectively, the "Recipient"), the following information:

- any and all information relating to my health (except psychotherapy notes) and my insurance policies and claims, including, but not limited to, information relating to any medical consultations, treatments, or surgeries; hospital confinements for physical and mental conditions; use of drugs or alcohol; and communicable diseases including HIV or AIDS.

I hereby authorize each of the following entities to provide the information outlined above:

- any physician or medical practitioner;
- any hospital, clinic or other health care facility;
- any insurance or reinsurance company (including, but not limited to, the Recipient or any other AIG American General company which may have provided me with life, accident, health, and/or disability insurance coverage, or to which I may have applied for insurance coverage, but coverage was not issued);
- any consumer reporting agency or insurance support organization;
- my employer, group policy holder, or benefit plan administrator; and
- the Medical Information Bureau (MIB).

I understand that the information obtained will be used by the Recipient to:

- determine my eligibility for benefits under and/or the contestability of an insurance policy; and
- detect health care fraud or abuse or for compliance activities, which may include disclosure to MIB and participation in MIB's fraud prevention or fraud detection programs.

I hereby acknowledge that the insurance companies listed above are subject to federal privacy regulations. I understand that information released to the Recipient will be used and disclosed as described in the AIG American General Notice of Health Information Privacy Practices, but that upon disclosure to any person or organization that is not a health plan or health care provider, the information may no longer be protected by federal privacy regulations.

I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization or other law allows the Recipient to contest a claim under the policy or to contest the policy itself, by sending a written request to: AIG Claims Department, P.O. Box 43119, Las Vegas, NV 89116-1119. I understand that my revocation of this authorization will not affect uses and disclosure of my health information by the Recipient for purposes of claims administration and other matters associated with my claim for benefits under insurance coverage and the administration of any such policy.

I understand that the signing of this authorization is voluntary; however, if I do not sign the authorization, the Companies may not be able to obtain the medical information necessary to consider my claim for benefits.

This authorization will be valid for 24 months or the duration of any claim for benefits under my insurance coverage, whichever is later. A copy of this authorization will be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

Name_____
Date_____
Signature of Claimant/Guardian/Representative

FOR RESIDENTS OF:

ALASKA: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

ARKANSAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

CALIFORNIA: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DELAWARE: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete or misleading information is guilty of a felony.

INDIANA: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete or misleading information commits a felony.

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

LOUISIANA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MAINE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NEVADA: Any person who misrepresents or falsifies essential information requested on this form may, upon conviction, be subject to a fine and imprisonment under state or federal law, or both.

NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW MEXICO: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

OREGON: Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law.

PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

TENNESSEE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

TEXAS: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

VIRGINIA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

WASHINGTON: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

WEST VIRGINIA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

FOR RESIDENTS OF ALL OTHER STATES NOT LISTED ABOVE:

Warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim, containing any materially false information, or conceals for the purpose of misleading, information concerning any facts materially thereto, commits a fraudulent insurance act, which may be a crime and subject such person to criminal and civil penalties.